THE WELLNESS INSTITUTE

MEDICAL HISTORY

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. **If you do not understand a question, leave it blank and your therapist will assist you.** Thank you!

NAME: ______________________________ OCCUPATION: ______________________________

Age: __________ DOB:______________ Height: ____________ Weight: ______________

Leisure Activities: ____ *BMI: ______________

(*Therapist will calculate BMI)

Allergies: List any medication(s) you are allergic to: ________________________________

Are you latex sensitive? Yes No List any other allergies we should know about: ______________

Are you currently seeing any of the following?

Medical doctor (M.D.)	YES NO	Psychiatrist/Psychologist	YES NO
Osteopath (D.O.)	YES NO	Chiropractor	YES NO
Physical therapist	YES NO	Other ______________	
Home Health Care	YES NO		

Have you had Physical Therapy during this calendar year?__________If so, approximately how many visits have you had?__________________________.

Have you EVER been diagnosed as having any of the following conditions?

YES NO Cancer If YES, describe what kind and When: ______________________

YES	NO	Heart problems	YES	NO	Other arthritic conditions
YES	NO	Pacemaker	YES	NO	Metal implants
YES	NO	High blood pressure	YES	NO	Depression
YES	NO	Circulation problems	YES	NO	Hepatitis
YES	NO	Asthma	YES	NO	Tuberculosis
YES	NO	Emphysema/Bronchitis	YES	NO	Stroke
YES	NO	Chemical dependency (i.e., alcoholism/drugs)	YES	NO	Kidney disease
YES	NO	Thyroid problems	YES	NO	Anemia
YES	NO	Diabetes	YES	NO	Epilepsy
YES	NO	Multiple sclerosis	YES	NO	Arthritis
YES	NO	Other Arthritic conditions	YES	NO	Headaches
			YES	NO	Mental Illness
			YES	NO	Other

Please describe any significant injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury:

DATE INJURY

1. __________ ______________________________ 2. __________ ______________________________

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization.

DATE TYPE OF SURGERY

1. __________ ______________________________ 2. __________ ______________________________

3. __________ ______________________________ __________ ______________________________

How much caffeinated coffee or caffeine containing beverages do you drink per day? ________

How many packs of cigarettes do you smoke a day? ________

Have you recently noticed:

YES	NO	Weight loss/gain	YES	NO	Fever/chills/sweats
YES	NO	Nausea/vomiting	YES	NO	Numbness or tingling
YES	NO	Fatigue	YES	NO	Dizziness / Blurred Vision
YES	NO	Weakness			

FOR WOMEN: Are you currently pregnant or think you might be pregnant? YES NO

I certify that all information provided herein is true and correct.

____ **Date:** ____________________
(Patient's Signature)

THE WELLNESS INSTITUTE
MEDICATION INTAKE FORM

Please list any PRESCRIPTION or OVER-THE-COUNTER medication you are currently taking (INCLUDING pills, injections, and/or skin patches):

Please include the strength (mg) and frequency (times per day) of all medications:

Name of Medication:	Strength:	Frequency:

I certify that all information provided herein is true and correct.

____ **Date:** ____________________
(Patient's Signature)

The Wellness Institute

Compass Rehabilitation - OKATIE
100 Okatie Center Blvd., North
Okatie, SC 29909

P: (843)547-4058
F: (843)705-7411
F: (866)500-4565

Compass Rehabilitation -HHI
1 New Orleans Rd STE 1E
Hilton Head Island, SC 29928

PATIENT INFORMATION

Date: ______________

First Name: ________________________ MI: ____ Date of Birth: _____/_____/_____

Last Name: ________________________________ Social Security Number: ______/______/______

Preferred Name: ____________________________ Female / Male

Home Address: _____________________________ Marital Status: Single Married Other

City: ____________________________________ Home Phone: _________________________

State: ___________________________________ Cell Phone: ___________________________

Zip Code: _____________ E-mail address: ________________________

Employment Status: Employed Full-time Student Part-time Student N/A

Employer Name/School Name: ____

Work Phone: _________________ Title/Position: _______________________

** In order to efficiently service your account, we have permission to contact you by any means listed above including cell phone, email and/or mailing address. ___________ **Initials.**

EMERGENCY CONTACT OR LEGAL GUARDIAN INFORMATION

First Name: ______________________ MI: ___ Home Phone: _________________

Last Name: _______________________ Cell Phone: __________________

Relationship: Spouse Parent Other _______________

REFERRING PHYSICIAN INFORMATION

Name: _______________________________ Phone Number: ______________________

REASON FOR TODAY'S VISIT

In which area of the body is your chief complaint? Neck Shoulder Elbow/Wrist/Hand Back Pelvis Hip/Knee/Ankle/Foot Other_____________

PLEASE TELL US HOW YOU HEARD ABOUT US

My Doctor_____________________ Advertisement(source) _____________________________

Family/Friend __________________ Internet Search: Google Facebook Other_______

Other__________________________ Insurance Website ___________________

Previous patient _________________

ASSIGNMENT OF BENEFITS / AUTHORIZATION TO RELEASE MEDICAL INFORMATION / AUTHORIZATION FOR TREATMENT

I hereby assign all medical benefits to which I am entitled to the Wellness Institute and Compass Rehabilitation, LLC, including Medicare, private insurance, and third party payers. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize said assignee to release all information necessary, including medical records, to secure the payment of said benefits. A photocopy of this assignment shall be considered as effective and valid as the original. I also understand that it is my responsibility to determine the physical therapy benefits that apply to my specific insurance plan. This includes but is not limited to, necessary doctor referrals or prescriptions, deductibles, copays and yearly coverage.

The undersigned hereby authorizes staff of the Wellness Institute, and Compass Rehabilitation LLC to provide physical therapy treatments deemed necessary for my care. I understand that this type of treatment involves the use of touch for diagnosis and treatment and that my therapist will explain this approach to me.

______________________________ ______________________________ ____________

Signature of Patient or Party Responsible for Bill **Printed Name** **Date**

RECEIPT OF NOTICE OF PATIENT PRIVACY PRACTICES

HIPAA NOTICE OF PRIVACY PRACTICE is available on file for your review.

CANCELLATION/NO SHOW POLICY:

If you cancel (or No Show) for your appointment with less than 24 hours' notice, there will be a $50.00 fee imposed.

This policy is in place out of respect for our therapists and our patients. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that appointment time.

Thank you for your understanding and cooperation.

Please initial that you have reviewed and understand our HIPAA and Cancellation policies.________

Initials

BILLING INFORMATION

Welcome to the Wellness Institute. We are excited to work with you and be a part of your healthcare team. Please know we do our best to assist you in understanding your insurance benefits. **However, it is your responsibility to know your insurance coverage and benefits.**

INSURANCE COVERAGE

Please note that **quoted benefits are not a guarantee of payment.**

PATIENT PAYMENTS

Co-pays are expected at the time of service. Please let us know if you need a receipt and we will be happy to provide one for you. Coinsurance amounts are fully calculated after your insurance has processed the claim. For information regarding this percentage, contact your insurance company. In addition, once the claim is processed, you should receive an EOB (Explanation of Benefits) from your insurance company, detailing the "amount paid by insurance" and the "patient responsibility."

CASH PAY

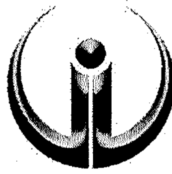
Payment is expected at time of service. The rate quoted to you is an already discounted rate.

THIRD PARTY PAYERS

At this time, we are able to accept 3rd party payers on a limited basis. This will be determined on a case-by-case basis and will need to be discussed with Compass Rehabilitation staff prior to starting treatment. You always have the option of paying as a "cash pay" patient for each visit if you would like to reduce the cost of each visit.

I have read and understand the billing information listed above.

Signature: ______________________________ Date: ______________________

wellness institute  compass rehabilitation physical therapy

Cancellation & No Show Policy

Thank you for your business; we appreciate your time and commitment to your health. Due to limited availability of appointments with our dedicated professional staff we would appreciate **24 hour notice** of any appointments that you cannot attend so that we may allocate the appointment time to someone who is waiting.

We understand that emergencies arise and sometimes this is not possible. In this case please advise us as soon as possible. If more than 1 appointment missed without appropriate cancellation we reserve the right to charge a **$50.00 fee for each appointment**—this charge will be your responsibility and not be billed to your insurance company.

By signing you agree that you understand our Cancellation/No Show policy.

Thank you for your cooperation in this matter.

Name: ______________________________ Date: ______________

Financial Responsibility Statement

___ I understand and agree that my co-payment is due and payable at the time of service.

___ I fully understand that I am responsible for all payments on my account. I am responsible for any charges not covered by my insurance company.

___ I further understand that any fees quoted to me are an **ESTIMATE ONLY**. Coverages and benefits may change and vary depending on deductibles met, co-pays, annual maximums and other factors stipulated by my insurance company, but I am the responsible party.

___ I understand and agree that if I **DO NOT** have insurance, I am responsible to pay in full for services at time of each visit.

___ I acknowledge that after missing **ONE** consecutive appointment, I am required to pay for my no show fees before being scheduled again.

______________________________ ______________

Signature of Patient/Legal Guardian Date